PATIENT SAFETY

FEEDBACK

Patient Safety Reporting System
P.O. Box 4
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FEEDBACK shares excerpts of reports sent by VA personnel to PSRS. Actual quotes appear in *italics*. Created by an agreement between NASA and the VA in May 2000, PSRS is a voluntary, confidential and non-punitive reporting system. PSRS encourages VA personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

Double Trouble: Shots

A reporter described how CPRS and BCMA interacted in an event where a non-diabetic patient received two injections of insulin meant for another patient.

- *Resident MD wrote for insulin NPH human (10 units) subcutaneous for a patient recently transferred from ICU to the medical ward. He wrote the order on the wrong patient. BCMA makes it very easy to "click" on the wrong patient to write orders or progress notes.*

In a series of handoffs from one nurse to another, nurses were not aware of the error:

- [The first nurse] *received report on patient with the transfer. His last glucose level was done* [about a year ago]. [The second nurse] *took off the order.* [The third nurse] *administered the first dose.* [The fourth nurse] *administered the second dose. After the second dose of insulin, patient suffered a hypoglycemic reaction... Lab serum value was 36 ... Staff responded appropriately and there were no lasting effects.*
- *What could prevent this from happening again:*
  - *CPRS changed so it is more difficult to write notes or orders on the wrong patient.*
  - *BCMA needs to display last relevant lab for high risk medication. Example: glucose for insulin, INR for coumadin, etc. If staff had realized last glucose had been done* [about a year ago] *perhaps would have stopped chain of events.*
  - *BCMA needs to have a means for requiring and documenting second verifier for high risk medication.*

NASA PSRS Executive Council Supports Safety Effort

The NASA PSRS Executive Council is composed of representatives from the VA National Center for Patient Safety, employee unions, VISNs, and facilities across the country. Headed by the PSRS Director, this council assists NASA in the continuous assessment of the progress and value of the PSRS. Pictured are members who attended the biannual meeting in January 2003. From left to right:

Front Row:
- **Dr. James Bagian**, Director, National Center for Patient Safety
- **Dr. Brian O'Neill**, Chief of Staff, VA Northern California Health Care System

Second Row:
- **Jacqueline Stemmons**, NFFE, New Orleans VA Medical Center
- **Chris Tucker,** National BCMA Project Manager, Pharmacist, ADPAC, Topeka VA Medical Center
- **Colleen Murphy**, UAN, VA Western New York Health Care System Buffalo
- **Kathy Moorhead**, SEIU National Safety Representative, Erie VA Medical Center
- **Donna Burgess**, NAGE, Coatesville VA Medical Center
- **Linda Connell**, PSRS Director, NASA Ames Research Center

Back Row:
- **Rodney Williams**, Program Manager, National Center for Patient Safety
- **Dr. Jamie Robbins**, Chief Medical Officer, VISN 18 Southwest Network
- **William Wetmore**, AFGE/NVAC, Central Office, VACO
- **Cathy Billiter**, UAN, Augusta VA Medical Center
- **Kimberly Jones**, SEIU, VA Western New York Health Care System Buffalo

Executive Council members not pictured:
- **Patricia Quigley**, UAN, Tampa VA Medical Center
- **Ronald Reynolds**, NAGE National Safety Representative, Lexington VA Medical Center
- **Oscar Williams**, AFGE/NVAC, Illiana Health Care System

And More Double Trouble: Pills

Two reporters discovered some medications from the prepackaging Pharmacy process with labels and dosages that did not match. The first nurse wrote:

- *Sometimes the package inadvertently has two pills instead of one. The barcode, however, will still scan for the correct one pill dosage regardless of what is in the package. This may give the nurse the impression that the entire contents of the package is one dose. The result is a double dose medication error that will go unnoticed. We have two pills erroneously put into packages on a daily basis.*

The second nurse found:

- *Metoprolol tartrate packaged as 50 mg. contained 2 tablets (100 mg. total)...In the patient's medication drawer were 6 doses for the weekend coverage, all with 2 pills... Pharmacy was notified. They told me that I should "throw one away!"*

Dangerous Gas Station

During a safety inspection, a reporter discovered a non-commercially-manufactured medical gas regulator.

- *The regulator was apparently assembled locally from pieces and parts of older regulators…The reassembled regulator was connected at the wall to an oxygen connection and would be used probably to provide oxygen for a patient.*
- *Having pieces and parts for both oxygen and air creates confusion as to whether it will supply air or oxygen for use. In addition, the use of oxygen for an air application or use of the air flow meter for calibrated oxygen use could create problems. This flow meter was immediately removed from service...*
- *The existence of a reassembled unit shows the possibilities of potential patient safety issues resulting from using parts from older or broken items to make a new unit.*

The reporter expressed concern about liability if this unit malfunctioned. It was found in a location where it probably was not being used as actively as it would be on a patient floor. If it had been needed on a clinical floor, however, the reporter felt that the unit could have posed a risk to patient safety.

Reaching for Help

Two reporters wrote separately about safety equipment in restrooms and bathrooms. First, in a clinic setting:

- *The outpatients use the laboratory restrooms and they are not equipped for handicapped patients. Several times I've had to go into the lab's restroom to help a wife get her husband off the toilet because there is only one rail for the patient to hold on to.*

Second, in a hospital environment, a reporter found that the emergency call button in the bathrooms is at such a high level on the wall that:

- *A fallen patient cannot reach it for help.*

Close Call, Close Quarters

Doorways in some clinical areas are too narrow for current wheelchairs.

- [The doorway] *is not large enough to accommodate the larger electric and manual wheelchairs... While performing venipuncture, a phlebotomist has called an outpatient into the drawing room. They can't come straight into the room because their wheelchairs are too large. They end up wrenching one or both arms between their wheelchair and the door.*

Another reporter wrote:

- *The doors to the restrooms are not wide enough so the patients have to get out of their wheelchairs to go in, then fall down in the process...Our restrooms are the highest used in the entire hospital with an average of 300 patients a day.*

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